ASAP TRIAGE INSTRUMENT (for Unscheduled Patients)

For use of this form see AR 40-66; the proponent agency is OTSG

1. DATE *(YYYYMMDD)*	2. NAME OF COMMANDER
3. SEX	4. UNIT TELEPHONE NUMBER

5. YOUR REASON FOR COMING IN

6. DATE OF LAST ALCOHOL USE *(YYYYMMDD)* HOW MUCH?

7. DATE OF LAST DRUG USE (*specify drugs*) *(YYYYMMDD)* HOW MUCH?

8. ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS? *(check those that apply.)*

	a. BREATHING PROBLEMS.		e. DELUSIONS/HALLUCINATIONS.
	b. NAUSEA.		f. SEIZURES.
	c. TREMORS.		g. DEPRESSION.
	d. PAINS, SPECIFY:		h. OTHER:

9. HAVE YOU EVER BEEN ENROLLED IN AN ALCOHOL OR OTHER DRUG PROGRAM? iF YES, PLEASE GIVE DATES ENROLLED AND A BRIEF SUMMARY OF WHY YOU WERE ENROLLED.

10. WHAT ALCOHOLIC BEVERAGES OR OTHER DRUGS DO YOU PRESENTLY USE?

a. WHICH ONES ARE CAUSING YOU THE MOST PROBLEMS?

b. HOW IS IT AFFECTING YOUR WORK?

c HOW IS IT AFFECTING YOUR FAMILY LIFE?

d. HOW IS IT AFFECTING YOUR PERSONAL LIFE?

PATIENT IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

11. DO YOU PRESENTLY NEED TO CONTINUE DRINKING OR USING OTHER DRUGS SO YOU CAN AVOID HAVING THE SHAKES, DEPRESSION OR OTHER UNCOMFORTABLE FEELINGS?

12. DO YOU NEED TO DRINK OR TAKE OTHER DRUGS TO HELP YOU COPE? ☐ YES ☐ NO IF YES, EXPLAIN.

13. a. ARE YOU CONTEMPLATING SUICIDE? ☐ YES ☐ NO IF YES, EXPLAIN.

b. HAVE YOU EVER CONTEMPLATED SUICIDE IN THE PAST? ☐ YES ☐ NO IF YES, EXPLAIN.

14. ARE THERE ANY OTHER COMMENTS YOU WISH TO MAKE?

****THIS SECTION FOR COUNSELOR USE ONLY****

1. PATIENT STATUS: ☐ Routine ☐ Acute

2. IMMEDIATE SERVICE PROVIDED:

3. DISPOSITION:

4. COUNSELOR'S SIGNATURE